Delta Dental of Iowa
City of Iowa City - Plan 1

Employee Summary of Covered Services and Benefits

Deductibles, Maximums & Eligibility	Delta Dental Premier®	
- Individual Deductible	$25	
- Family Deductible	$75	
- Deductible applies to Check-Ups and Teeth Cleaning?	No	
- Benefit Period Maximum	$500	
- Eligible children through age	25	
- Full-time (unmarried) students eligible through age	99	
Benefits		
Diagnostic and Preventive Services (Check-Ups and Teeth Cleaning)	0%	
- Dental Cleaning		*2 in a benefit period aggregate with perio maintenance therapy*
- Oral Evaluations		*2 in a benefit period*
- Fluoride Applications		*1 every 6 months*
- X-Rays		*Bitewings - 1 every 12 months; Full mouth - 1 every 3 years*
- Sealant Applications		*Not Covered*
- Space Maintainers		*Through age 14*
Routine and Restorative Services (Cavity Repair and Tooth Extractions)	50%	
- Emergency Treatment		
- General Anesthesia/Sedation		
- Restoration of Decayed or Fractured Teeth		
- Limited Occlusal Adjustments		
- Routine Oral Surgery		
- Posterior Composites w/ Alternate Processing		
Root Canals (Endodontic Services)	50%	
- Apicoectomy		
- Direct Pulp Cap		
- Pulpotomy		
- Retrograde Fillings		
- Root Canal Therapy		
Gum and Bone Diseases (Periodontal Services)	50%	
- Conservative Procedures (Non-surgical)		*1 every 24 months per quadrant*
- Complex Procedures (Surgical)		*Not Covered*
- Periodontal Maintenance Therapy		*2 in a benefit period aggregate with dental cleaning*
High Cost Restorations (Cast Restorations)	50%	
- Cast Restorations		
- Crowns		*1 every 5 years*
- Inlays		*1 every 5 years*
- Onlays		*1 every 5 years*
- Post and Cores		*1 every 5 years*
- Recementing Crowns/Inlays/Onlays		
Dentures and Bridges (Prosthetic Services)	Not Covered	
- Bridges		
- Dentures		
- Repairs and Adjustments		
- Recementing of Bridges		
- Implants		
Straighter Teeth (Orthodontics)	Not Covered	
Additional Options		
-Enhanced Benefits Program	Included	

This dental plan includes the Enhanced Benefits Program (EBP) which allows additional benefits for Covered Person(s) with designated dental or medical conditions. Please refer to your dental benefits document for details.

The percentage shown is the coinsurance amount that is the responsibility of the Covered Person.

This is a general description of coverage. It is not a statement of your contract. Actual coverage is subject to terms and conditions specified in the benefits document itself and enrollment regulations in force when the benefits become effective. Certain exclusions and limitations apply. Please refer to your dental benefits document for details.

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